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Millard v. ABCO Construction, Inc Respondent's Brief Dckt. 43618

BEFORE THE SUPREME COURT OF THE STATE OF IDAHO

THOMAS C. MILLARD, Claimant/Appellant, vs. ABCO CONSTRUCTION, INC., Employer, and WORKERS COMPENSATION FUND OF UTAH, Surety, Defendants/Respondents.	)	**Supreme Court Docket No. 43618**

RESPONDENTS' (EMPLOYER/SURETY) BRIEF

APPEAL FROM THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

Chairman R.D. Maynard Presiding

James D. Ruchti, Esq.
Richti & Beck Law Offices
1950 E. Clark Street, Suite 200
Pocatello, ID 83201
Telephone: (208) 478-5100

Attorney for Appellant

R. Daniel Bowen, Esq.
Bowen & Bailey, LLP
P.O. Box 1007
Boise, ID 83701-1007
Telephone: (208) 344-7200

Attorneys for Respondents

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I.

STATEMENT OF THE CASE

This is an appeal taken by Claimant/Appellant Thomas Mr. Millard (hereinafter "Millard" or "Mr. Millard") from two particular rulings by the Industrial Commission in a case involving a number of rulings. Mr. Millard was badly injured in an industrial accident that occurred on October 9, 2006. At the time of his injury his employer, ABCO Construction, Inc., had workers' compensation coverage through the Workers Compensation Fund of Utah (hereinafter collectively referred to as "Defendants"). The Workers Compensation Fund of Utah, (hereinafter singularly referred to as "Surety") accepted the claim and began paying benefits immediately. The claim was initially handled as a Utah claim, because at the time the claim arose the Surety was unable to provide extraterritorial coverage and, hence, process claims under the laws of any other state.

Shortly after the accident and injury Mr. Millard became unhappy with the handling of his claim. He hired an attorney and filed a Complaint with the Industrial Commission of the State of Idaho in March of 2007 seeking to have his claim processed as an Idaho claim. The Surety sought legal counsel in Idaho and filed a response to the Complaint advising that they would process Mr. Millard's claim as an Idaho claim. They assigned an Idaho in-state adjuster, Carole Carr, to adjust the claim, and she has adjusted it since that time as an Idaho claim. The claim has been in continuous litigation since March of 2007. As of the time the Industrial Commission decided this case, a little over $246,329.69 had been paid on the claim by Surety. As of the date of this brief, $282,261.46 in medical benefits have been paid on the claim.

Over the years there have been numerous disputes between the parties, but for the most part the parties were able to come to resolution of the issues, be they the extent of Mr. Millard's disability or his entitlement to particular forms of medical care. The Surety conceded total permanent disability in 2012. Lingering issues regarding medical expenses existed at that time and continued to plague the parties over the next couple of years. In addition, issues arose as to whether ongoing epidural steroid injections provided by Dr. Vikas Garg were reasonable as contemplated by Idaho Code § 72-432. These various issues culminated in a hearing conducted by the Industrial Commission of the State of Idaho on November 6, 2014. The Industrial Commission issued its decision in the matter on August 21, 2015.

The Industrial Commission concluded that Mr. Millard had established he was entitled to reimbursement of all medical charges for Dr. Garg's treatment from October of 2012 through the time he became an authorized provider in November of 2013. The Industrial Commission concluded that Dr. Garg's treatment from October of 2012 through the time he became an authorized provider in November of 2013 had to be reimbursed at the full invoiced amounts per the *Neel* Doctrine. The Industrial Commission concluded that Mr. Millard was entitled to mileage and associated travel expenses for Mr. Millard's treatment with Dr. Garg from October 2012 through the time he became an authorized provider in November of 2013. The Industrial Commission concluded that Mr. Millard had failed to establish that he was entitled to continuing epidural steroid injections. The Industrial Commission concluded that Mr. Millard had failed to prove he was entitled to reimbursement for the full invoiced amounts of past prescriptions and physical therapy charges. The Industrial Commission concluded that the Surety had

unreasonably denied and/or had unreasonably delayed payment on various medical issues including treatment and responses to requests for change of physician.

There is a clerical error contained in the Industrial Commission decision of note. The Industrial Commission Finding of Fact No. 6 reads as follows:

> From October 2012 until October 2013, Claimant sought care from Vikas Garg, M.D. of Logan, Utah without prior authorization of Surety. Thereafter, Surety authorized continuing treatment with Dr. Garg.[2] Defendants' position is clear and straight forward – Dr. Garg was not an authorized treater during the 2012 – 2013 time frame, and thus under Idaho Code § 72-432(5), such treatment is not reimbursable. Claimant argues that Surety's failure to provide reasonable treatment, or even respond in a meaningful way to Claimant's request for change of physician, allowed him to seek treatment with Dr. Garg at Surety's expense.

(Industrial Commission Findings of Fact, Conclusions of Law, and Recommendation, Finding of Fact 6, p. 5). Footnote 2 itself reads:

> Dr. Garg's last treatment during the time contested was in October 2013. However, from the exhibits provided, it appears Dr. Garg was not approved as a provider until November 2013. This fact is not important for the ruling herein, but Defendants at several places in their briefing state that Dr. Garg was approved by the Surety in mid-October 2013, which does not appear to be accurate.

(Industrial Commission Findings of Fact, Conclusions of Law, and Recommendation, p. 5).

The import of these Findings of Fact is that they discuss the dispute over treatment from Dr. Garg provided from October 2012 to and perhaps through October 2013. Treatment thereafter was authorized by the Surety, and the Industrial Commission has made a finding of fact acknowledging such.

The reason that the foregoing is important is that under Conclusions of Law, No. 6, the Industrial Commission wrote as follows:

> Claimant has proven that he is entitled to attorney fees pursuant to Idaho Code § 72-804 for Surety's unreasonable denial of treatment with Dr. Garg from October 2013 through October 2014.

(Industrial Commission Findings of Fact, Conclusions of Law, and Recommendation, Conclusion of Law 6, p. 26). It is apparent from the reading of the decision as a whole that the Industrial Commission in its Conclusion of Law intended to say that Millard had proven he was entitled to attorney's fees for the unreasonable denial of treatment provided by Dr. Garg from 2012 up through October 2013.

While the attorney fee issue was being thrashed around by the parties, Mr. Millard's counsel filed a Notice of Appeal on October 1, 2015. The Industrial Commission finally entered their Order Granting Attorney's Fees on October 26, 2015. Mr. Millard's counsel requested that his attorney's fees be based upon an hourly charge. The fees per his claim totaled $28,752.50. Defendants suggested that attorney's fees based upon a contingency agreement were more appropriate. The Industrial Commission pointed out that Mr. Millard did not prevail on all issues and, therefore, should not receive the total amount of the fees requested on an hourly basis, because the bill that he submitted did not distinguish the work he did where attorney's fees were awarded and issues where attorney's fees were not awarded. They also noted that part of his attorney's fee claims based upon an hourly basis were at $185.00 an hour, and part of them were at $200.00 an hour, yet his attorney-client fee agreement only contemplated an hourly fee of $185.00 an hour. The Industrial Commission compromised and awarded Mr. Millard $22,000.00

in attorney's fees for the various unreasonable denials and delays as per their decision. All benefits awarded by the Industrial Commission and attorney's fees awarded have been paid by the Surety subject, of course, to the outcome of the current case on appeal before the Court.

II.

STATEMENT OF FACTS

Carole Carr has been adjusting Mr. Millard's claim for a number of years. (HT, p. 181, ll. 12-21). The claim has been in litigation the entire time she has adjusted the file. (HT, p.181, l. 23). This complicates her ability to adjust the file, because she cannot speak directly with Mr. Millard. (HT, p. 182, ll. 7-15). Ms. Carr believes that the prescription drug issues fired up at some point in about 2011 or 2012. (HT, p. 183, ll. 10-12). For some reason in 2011 Mr. Millard's pharmacy started billing Utah Workers Compensation Fund instead of sending the bills through Pinnacle Risk Management Services, the Idaho adjuster for the claim, such that Ms. Carr was not getting the prescription bills. (HT, p. 183, l. 20 – p. 184, l. 1). She called the pharmacy on several occasions advising them that they needed to send the bills directly to her office, but the complaints continued. (HT, p. 184, ll. 1-7). At some point in the fall of 2012 Ms. Carr asked the pharmacy to fax the prescription bills directly to her rather than to some vendor for review or to the Utah Workers Compensation, and she has been processing those prescription bills directly by paying full invoiced amount since. (HT, p. 184, l. 8 – p. 185, l. 10).

As to the physical therapy disputes, Ms. Carr was aware that Dr. Passey had prescribed a limited number of physical therapy sessions in April of 2011. (HT, p. 185, l. 19 – p. 186, l. 5). She was fine with physical therapy as prescribed by Dr. Passey, Mr. Millard's treating physician.

(HT, p. 186, ll. 7-10). Defendants believe that Mr. Millard sought some modest physical therapy pursuant to this prescription in the spring of 2011, but that he did not get any more physical therapy during the summer of 2011. (HT, p. 186, ll. 11-13).

Physical therapy apparently resumed in the fall of 2011, which Ms. Carr was not aware of. She became aware of it when she received bills for two to three months of physical therapy. This exceeded the number of visits that Dr. Passey had recommended back in April. (HT, p. 186, ll. 20-23). She had no prescription from Dr. Passey in her possession that recommended treatment beyond what he had recommended in April of 2011. She called Dr. Passey's office to see if Mr. Millard had returned since April of 2011, and he had not, so she denied payment based upon her concerns that it had not been authorized or recommended by the treating physician. (HT, p. 187, ll. 1-6). Carole Carr became aware during her September 2014 deposition that there was a second prescription from Dr. Passey dated August 26, 2011. (HT, p. 187, ll. 14-25). At the time of the hearing she did not know whether this was a new prescription or a reiteration of the prescription from April of 2011. (HT, p. 188, l. 8).

Prior to Ms. Carr's deposition, Mr. Millard's counsel had provided a copy of the prescription in question to Defendants' counsel attached to a February 21, 2014 letter. (Hearing Ex. 4, p. 1001). This prescription was authored by Dr. Passey and dated August 26, 2011, and called for a physical therapy evaluation and treatment consult for neck and lumbar spine pain. (Hearing Ex. 44, p. 1001). It does not itself prescribe two to three months of physical therapy. Defendants' counsel, for whatever reason, did not see the prescription as he went through these records, which totaled a little under 200 pages. Defendants' counsel forwarded the letter and

these documents on to the adjuster, but Defendants' counsel had failed to highlight to his client that there was a prescription. Ms. Carr did not see the additional prescription either. Ms. Carr at hearing testified that if Dr. Passey was fine with the three months of therapy Mr. Millard incurred in the fall of 2011, she did not have a problem paying for that. (HT, p. 188, l. 20).

The plan at that time was to depose Dr. Passey and ask him whether he was okay with the three months of therapy provided. The point of this was, he had only prescribed a physical therapy evaluation and consult. Subsequently, Defendant Surety made a decision not to expend any more resources exploring the issue and decided to accept and pay for the physical therapy. This required the physical therapist to unwind the Medicare payments that had been made for that therapy. Defendants advised the Industrial Commission in their Post-Hearing Brief that Medicare payments had been unwound, bills had been sent to the Surety, and the Surety had paid the physical therapy bills, which, utilizing the fee schedule, came to $1,791.20. The Surety had processed the bills and made payment on February 9, 2015. The physical therapy in question at full invoiced amount was $2,239.00. Thus, the remaining difference is $447.80.

Dr. Passey, a Utah physician, had become Mr. Millard's treating physician as a result of a Petition for Change of Physician put to the Surety by Mr. Millard's former attorney a number of years ago. The Surety had agreed to that request. Ms. Carr thought that Dr. Passey provided good services to Mr. Millard. (HT, p. 190, ll. 13-21). In approximately June of 2012, in the context of trying to resolve the questions regarding Mr. Millard's disability, Ms. Carr became aware that Mr. Millard was unhappy with Dr. Passey, because he had communicated with Defendants' counsel. (HT, p. 191, ll. 3-10). Furthermore, she was aware that at some point in the summer of

2012 Mr. Millard wanted to change his treating physician, and Ms. Carr was not inclined to make that change. (HT, p. 191, ll. 11-24). Her reluctance to change physicians was conveyed to Mr. Millard's counsel's office in early 2012, consistent with Ms. Beck's testimony. (HT, p. 191, l. 25 – p. 192, l. 4).

Subsequently, on June 25, 2013, Mr. Millard filed a Petition for Change of Physician requesting that Dr. Clegg be Mr. Millard's treating physician. The Industrial Commission decision erroneously characterized this as a Petition for Change of Venue. (Findings of Fact, Conclusions of Law, and Recommendation, Finding of Fact 14, p. 7). Defendants, on July 9, 2013, agreed to the request. Dr. Clegg declined to be the treating physician, and Mr. Millard's counsel so advised Defendants by letter dated August 8, 2013. (Hearing Ex. 32, p. 925). Conversations continued and another Petition for Change of Physician requesting Dr. Garg was filed by Millard on October 30, 2013. On November 21, 2013, the Surety filed a response authorizing Dr. Garg to perform epidural injections.

Ms. Carr felt that since Mr. Millard was obviously not going to go back to see Dr. Passey, the Surety ought to get on board and provide him with a treating physician. She agreed that Dr. Garg could become a treating physician in the fall of 2013. She started receiving bills for the injections which Dr. Garg undertakes. She got these from Cache Valley Hospital for injections done on October 15, 2013 and November 26, 2013. She paid them. (HT, p. 194, ll. 3-12). She was not receiving any additional or separate bills from Dr. Garg. (HT, p. 194, l. 16). She was not receiving any medical records other than the procedural reports she was receiving from Cache Valley Hospital, along with their billings. (HT, p. 194, l. 20). She was unaware that there were

other billings or other medical reports out there other than what she was receiving from Cache Valley. (HT, p. 194, l. 23). She did not become aware that there were separate billings from Dr. Garg until August 28, 2014, when she received a call from Dr. Garg's office asking her whether they could send their bills to her for payment since Medicare had recently stopped paying for them. (HT, p. 195, ll. 5-11).

Ms. Carr encouraged Dr. Garg's office to send the bills and the reports to her and told Dr. Garg's office that they would be processed. (HT, p. 195, ll. 9-11). The same day Dr. Garg's office sent bills and reports for dates of service including February 11, 2014, May 22, 2014, June 19, 2014, August 9, 2014, and August 26, 2014. Along with that, they sent the accompanying chart notes. (HT, p. 195, ll. 13-24). As of the date of the hearing, Ms. Carr had made payment for all of Dr. Garg's services from 2011 through August 26, 2014, with the exception of three bills that had been paid by Medicare. (HT, p. 196, ll. 1-8). In talking to Dr. Garg's office on August 28, 2014, Ms. Carr learned that there were these additional three bills and treatments that had been paid by Medicare, and Ms. Carr advised Dr. Garg's office that she would be happy to process those bills. Ms. Carr advised at hearing that she was prepared to pay those as soon as the Medicare payments were unwound such that Dr. Garg's office could bill for those services. (HT, p. 197, ll. 5-13).

Mr. Millard argues for full invoiced amount under *Neel* for the medical incurred by Dr. Garg after 2013. The problem with that argument is that Defendants never denied any of that medical. Defendants paid it as they got it. The problem was, the only medical Defendants were getting were the operative/procedure notes that Dr. Garg authored out of Cache Valley Hospital

and the billings from Cache Valley. Defendants did not get anything from Dr. Garg, because he was billing it all to Medicare, and Defendants did not learn that until August 28, 2014.

By way of explanation, the Cache Valley reports, which were essentially reports documenting the injection procedures, contained no data as to how effective the procedures were. They just essentially stated what was provided in the way of a service that would support the billings. All the qualitative data was contained in Dr. Garg's chart notes, and at no point after Dr. Garg was authorized to be a treating physician was the Surety getting these until August 28, 2014. Because the Surety was not getting any information back regarding whether Mr. Millard was benefitting from the treatment, Defendants' counsel started writing Dr. Garg requesting such information, because of course he was the treating physician. Defendants' counsel wrote Dr. Garg on January 8, 2014, documenting that they had previously authorized Dr. Garg to provide care in the way of performing injections and that Defendants were aware that he had performed at least two. Defendants' counsel expressed some concerns in that letter regarding the costs given earlier representations made by Dr. Garg and their concerns about what benefit, if any, Mr. Millard was receiving from the injections that were being provided. The thrust of it was that Defendants needed some sort of an update. Defendants received no response from Dr. Garg and wrote him another letter on May 13, 2014, requesting the same information. In that letter Defendants' counsel made a representation that they would have problems authorizing additional injections absent some additional information, although Ms. Carr continued to pay for the Cache Valley bills she received subsequent to that point, and in fact, when she received information from Dr. Garg's office on August 28, 2014, also paid for additional services he provided

subsequent to the May 13, 2014 letter. These letters authored by Defendants' counsel were put into evidence as Hearing Exhibit 58, pp. 77-79. Dr. Garg never responded. The point of these letters in the present inquiry is that they buttress Defendants' contention that they were not receiving the chart notes and were not receiving separate bills from Dr. Garg, which chart notes contained much of the information Defendants needed as to what benefit, if any, the injections were providing. While the Industrial Commission in its opinion expressed concern about Defendants not being proactive, this is an example of where they were proactive and received no response from the treater, no medical records, and no billings.

III.

ISSUE PRESENTED ON APPEAL

Claimant has appealed and framed the issues as he sees fit. Defendants would suggest that the real issue is as follows:

Whether the *Neel* Doctrine should be expanded such that Mr. Millard should be awarded full invoiced amounts for physical therapy he underwent in the fall of 2011 and for injection therapy he underwent after October 3013.

IV.

ARGUMENT

A. The Industrial Commission Did Not Err in Declining to Apply the *Neel* Doctrine to the Physical Therapy Bills and the Injection Therapy Bills in Question.

In the case of *Neel v. Western Construction, Inc.*, 147 Idaho 146, 206 P.3d 852 (2009), the Court reviewed an Industrial Commission decision which involved a relatively new

interpretation of sureties' responsibilities to pay medical expenses. In the *Neel* case, the claimant claimed an accident and injury occurring on September 14, 2005, which resulted in extensive medical treatment, including surgery on his back. The surety denied that an accident and injury occurred. They denied the claim in its entirety. The matter went to hearing on September 26, 2006, and the defendants lost. The Industrial Commission concluded that the claimant had suffered an accident and injury, which in turn had made necessary all the medical he had incurred. The medical bills had not actually been submitted as part of the claim since the case was tried on the threshold issue of compensability, and such really was not necessary.

Subsequent to the Industrial Commission decision, the defendants requested that they be provided with the medical billings, and they were, along with a letter from the claimant's counsel making demand for the full invoiced amount of the medical bills based upon Industrial Commission decisions that started in 2004 with the case of *Sangster v. Potlatch Corp.*, 2004 IIC 0861. The defendants rejected the invitation to pay full invoiced amounts and paid the medical expenses utilizing the fee schedule required by Idaho Code § 72-432, § 72-508, and § 72-803 read together.

The claimant did not think this was sufficient and asked the Industrial Commission to review the legal issue posed in the context of a motion. The Industrial Commission entertained the motion and issued a decision requiring the defendants to pay all the medical incurred at the full invoiced amounts. The Industrial Commission's reasoning was that these medical bills, or many of them, having been incurred in the context of a denied claim, were incurred outside the realm of worker's compensation and worker's compensation regulations and potentially exposed

the claimant to the full invoiced amounts under a theory of contract. The fact that much of the claimant's medical that was incurred was paid for by a health carrier and undoubtedly subject to provisions of no balance billing, did not seem to be of consequence to the Industrial Commission.

Defendants took appeal, and the Idaho Supreme Court reviewed the matter. Mr. Millard raises an issue as to what the Idaho Supreme Court intended by its ruling in the *Neel* case. Defendants in *Neel* argued that all medical bills denied or accepted should be paid as per what was reasonable, consistent with the statutes and the regulations adopted by the Industrial Commission. The claimant in the *Neel* case argued that the surety, having denied a claim later determined to be compensable, should be forever barred from reviewing bills for reasonableness in amount. *Neel v. Western Construction, Inc.,* 147 Idaho 146 at P. 148, 206 P.3d 852 at P. 855 (2009). The arguments made by the defendants and the claimant in the *Neel* case were inherently based upon and grew out of a situation where the entire claim had been denied, and, hence, all the medical treatment had been denied. Otherwise, the position particularly argued by the claimant would make no sense. If, for example, the claim were otherwise accepted, and if some medical were being paid, but the defendants had denied one particular medical bill, how could anyone advance an argument that payment at full invoiced amounts should extend to all medical bills. The arguments utilized were never intended to address a situation where less than the entire claim was denied.

The Court found some merit in the arguments advanced by both sides. The Court wrote:

> The parties in this case argue for a resolution at opposite ends of the spectrum; Mr. *Neel* contends the surety should not be permitted to review any of his invoices for reasonableness, whereas surety asserts they should be permitted to review all of Mr. *Neel*'s invoices for reasonableness. In the interest of fairness, and to avoid awarding unearned incentives or windfalls to sureties or claimants, we construct a middle ground resolution that takes into account the policy behind the workers' compensation law.
>
> Thus we hold that sureties, having denied a claim subsequently deemed compensable by the Industrial Commission, are only permitted to review a claimant's medical bills incurred after the claim is deemed compensable to determine whether such bills are reasonable in accordance with the workers' compensation regulatory scheme. Any medical bills incurred during the time from which the accident occurred to the time when the claim was deemed compensable fall outside the workers' compensation regulatory scheme and may not be reviewed for reasonableness and must be paid in full by the surety.

Neel, 147 Idaho at P. 149, 2006 P.3d at P. 856. (Emphasis added). The Court's decision only makes sense if it is applied to those situations where a threshold issue of compensability results in the denial of the entire claim. If the denial is as to compensability, and effectively all medical expenses have been denied and thus potentially incurred outside the workers' compensation regulatory system such that there is some exposure for the claimant to have to pay full invoiced amount, the Court insists upon payment of full invoiced amount for all the medical incurred during the period of denial and prior to decision. It obviously cannot apply where the claim itself has been accepted and the surety and the claimant are simply arguing over a particular medical bill, not if the policy behind the *Neel* decision is to be served. If a surety, as in the present case, accepts a claim and pays over a quarter of a million dollars in medical expenses and pays total permanent disability benefits, they have not denied the claim. The mere fact that the Surety balked at paying some medical bills certainly cannot justify interpretation of the *Neel* case to the

effect that all medical incurred, even medical that was otherwise accepted and paid for during a period of time that one bill in particular was denied, must nonetheless be paid at full invoiced amount.

Medical bills accepted and paid as part of the worker's compensation claim were not incurred outside of worker's compensation, and Mr. Millard has no further obligations for the same per I.C. § 72-432, which prohibits balance billing. It makes no sense and works a horrific injustice on the Surety insofar as they properly paid other medical bills. Similarly, it would work to create an inexplicable windfall to a claimant, there being no further obligation to any provider.

The Industrial Commission's interpretation of the Court's decision in *Neel* is premised upon language that the Court chose to use in its holding. The language in pertinent part is, "Sureties, having denied a claim subsequently deemed compensable by the Commission." *Neel*, 2006 P.3d at P. 856 (emphasis added). There are some good reasons for that interpretation. First, that is what the Court said. Second, sureties, as in the present case, are presented with hundreds if not thousands of medical bills in any given matter. Some of those are going to be for services that are clearly due to the accident and injury and are clearly reasonable, as can be ascertained by the accompanying medical reports, which are required by Industrial Commission regulation to be submitted within 14 days of the service provided. Other treatments, even though included in the medical report and included in the medical bill, may on their face clearly not be compensable. For instance, if an orthopedic surgeon sends an industrial worker with a foot injury to a physical therapist who also happens to note that the injured worker also has a nonindustrial hand problem and prescribes therapy for that, no one would dispute the physical therapy bill sent to the surety

that included physical therapy charges for both the hand and the foot was compensable. It is legitimate for the surety in that instance to segregate out and pay only those charges associated with the industrial accident and injury. In another case, the same orthopedic surgeon may refer an injured worker with a knee injury for physical therapy both for the knee and for the low back and not specify document in the accompanying chart note that they think that the low back injury is in some fashion related to the knee injury. The therapist then prepares a bill for both and submits it to the surety, and the surety denies the low back. At that point the issue as to the causal relationship usually gets on the radar, and it may very well be that the orthopedic surgeon will clarify in a subsequent chart note that he believes the low back problems for which he prescribed therapy are in fact in some fashion related to the industrial knee injury, because he believes the altered gait from the knee injury produced the back problem. Under such circumstances, with the clarification, the surety might well reconsider their denial and pay the balance of the physical therapy payment once they have clarification of the issue. Why should they be discouraged from doing so by an overly aggressive application of the *Neel* Doctrine. If they are going to have to pay full invoiced amount no matter what they do with the bill, might not their willingness to concede payment decline?

Whether reasonable or unreasonable, the Surety was unaware that there was a second potential prescription for physical therapy Mr. Millard incurred in the fall of 2011. To be candid, the issue as to whether Dr. Passey truly prescribed two to three months of physical therapy in the fall of 2011 is still an open question. The prescription upon which Millard relied below is a prescription for a "physical therapy evaluation and consultation." (Hearing Ex. 44, p. 1001). It is

not a prescription for three months of therapy. It was a request that an evaluation be done making recommendations regarding the propriety of therapy. To Defendants' knowledge, there is no followup from Dr. Passey in the record. The whole bill for the physical therapy was frankly less than what it was going to be to depose Dr. Passey. It is true the Surety was initially reluctant to pay for the therapy, but reconsidered its position and did pay it. It is equally true that they did so prior to the issuance of the Industrial Commission decision.

While the Industrial Commission was not happy with what they considered to be the Surety's tardiness in paying the bill, they punished the Surety by awarding attorney's fees under Idaho Code § 72-804, which is their prerogative, and which attorney's fees the Surety has paid. However, there is no dispute but that the physical therapy in question was paid before the claim for such was deemed compensable by the Industrial Commission, and as such, *Neel* on its face does not apply as found by the Industrial Commission.

The same argument obviously applies to the injection therapy provided by Dr. Garg. There are, however, additional arguments as to why Dr. Garg's bills should not be included under a *Neel* analysis.

B. Dr. Garg's Treatment Subsequent to October 2013 Should Not Fall Under the *Neel* Doctrine, Because the Treatment was Never Denied.

Mr. Millard's counsel was awarded both attorney's fees and full invoiced amount of the bills under the *Neel* Doctrine for Dr. Garg's treatment prior to October 13, 2013. The Conclusion of Law No. 6 states that attorney's fees are awarded for the period of October 2013 through October 2014, but a reading of the opinion in its entirety clearly indicates that this was merely a

clerical error and the Industrial Commission meant the period of October 2012 through October 2013. The problem with Mr. Millard's argument for application of the *Neel* Doctrine as to injection therapy after October 2013 is that it was never denied. The Industrial Commission decision contains no finding of fact stating such, nor could it. The treatment was accepted as established by Finding of Fact No. 6, which acknowledges that the Surety authorized treatment by Dr. Garg after October 13, 2013 (Findings of Fact, Conclusions of Law, and Recommendation, p. 5), and all bills submitted were paid. Thus, as to the injection therapy in question, one can argue the claim itself had never been denied such that *Neel* is not applicable, and in the alternative, one can argue that the claim for these particular treatments was never denied. To the contrary, the Surety authorized the injection therapy by Dr. Garg in November of 2013 as per the Industrial Commission decision, and the Surety paid for all bills submitted in connection therewith.

A problem arose, because Surety was only receiving medical reports and bills from Cache Valley up until August 28, 2014. Defendant Surety paid all the Cache Valley bills as they came in, but was unaware that there were separate chart notes and separate bills from Dr. Garg, because Dr. Garg's office failed to send them to the Surety in violation of I.C. § 72-432(11), which states:

> All medical information relevant to or bearing upon a particular injury or occupational disease shall be provided to the employer, surety...(emphasis added).

This requirement is amplified by Industrial Commission regulation IDAPA 17.02.04.322.02.a, which requires the following:

> In all cases in which a particular injury or occupational disease results in a worker's compensation claim, the provider shall submit written medical reports for each medical visit to the payor...These reports shall be submitted within 14 days following each evaluation, examination, or treatment.

Dr. Garg's office, for whatever reason, in spite of letters and conversations with him in November 2013, letters in January of 2014 and in May of 2014, did not provide chart notes or billings until August 28, 2014.

Defendants only became aware of these additional records and bills on August 28, 2014, when Dr. Garg's office called the adjuster, advised that Medicare was no longer paying, and asked if they could submit their bills to work comp. The Surety's response on that occasion was sure, send them and we will pay them. The Surety paid every bill submitted to them by Dr. Garg's office.

C. The *Neel* Doctrine Should Not Apply when the Surety Proves Mr. Millard has No Exposure for Full Invoiced Amounts.

The reasoning behind the *Neel* Doctrine ultimately boils down to the fact that when a claim is denied, a claimant goes out and in theory contracts directly with medical providers for medical services, potentially exposing him to pay the full invoiced amount that appears on their bills. The notion is that a claimant, having done so, the claim subsequently determined compensable, and hence the medical bills contracted for compensable, the surety should have to retire all of his potential obligations by handing over to the claimant and/or his attorney the full invoiced amount of the medical incurred.

While one can certainly question the rationale behind the *Neel* Doctrine to the extent it only deals with potential exposures rather than established obligations to pay full invoiced

amount, there certainly can be no justification for the application of the doctrine where the surety establishes that the claimant has no exposures for full invoiced amount of the medicals incurred during the period of denial. In the instant case, there are two different sets of medical expenses involved. There is the period of physical therapy that was incurred in the fall and early winter of 2011. Trudi Beck testified that these bills were submitted to Medicare and paid for by Medicare. Trudi Beck's testimony establishes that Mr. Millard was out of pocket several hundred dollars. Her testimony further establishes that other than Mr. Millard's out of pocket, acceptance of Medicare payment by the medical provider means that he is not able to balance bill. She testified that for him to do so would be a crime. That being the case, it is clear that Mr. Millard has no exposures for full invoiced amount of the medical, and, therefore, there is no justification for application of the *Neel* Doctrine.

The other medicals involved in this appeal, which are Dr. Garg's bills for services provided from November 2013 onward, similarly present no exposures to Mr. Millard for full invoiced amount. This is so, because Dr. Garg's services were not denied and were in fact accepted under the workers' compensation system. It is true that his office failed to bill the worker's compensation Surety and billed Medicare instead for some of the services provided after that date. However, Dr. Garg's office, having billed Medicare and having accepted Medicare payments, again, there is no exposure for Mr. Millard for full invoiced amount, and, therefore, no reason to demand reimbursement under the *Neel* Doctrine, which is based upon an assumption that there are such exposures. The fact of the matter is, this care was accepted and thus came under the Workers' Compensation Act, which also prohibits balance billing. I.C. § 72-

432(6). Similarly, having been referred to a particular medical provider by the employer, a claimant is not responsible for the payment of the treatment that he provides. I.C. § 72-432(7). The fact of the matter is, as outlined supra, there were no exposures anyway to the extent there was never any denial – there simply was a failure of Dr. Garg's office to timely submit reports and billings. Under these circumstances, Defendants are hard pressed to figure out any meaningful explanation as to why they should have to tender full invoiced amounts to Mr. Millard and his counsel when the bills do not present any risk of full invoiced exposures for Mr. Millard, all bills submitted were paid by the Defendant Surety at the appropriate rates established under the statutes and regulations of the workers' compensation system utilized here in Idaho prior to the entry of a decision.

D. Millard's Counsel is Not Entitled to Attorney's Fees on Appeal.

Millard's counsel is not entitled to an attorney's fee appeal, basically because he should not win on either of the two substantive issues he presents for the Court's review and should not win on appeal as per arguments made supra.

Millard's counsel argues for an extension of *Neel*. In other words, this is a case of first impression. The Court has never been asked to address the application of *Neel* in an instance where something less than the full claim has been denied. The Court has never been asked to review the issue as to whether *Neel* applies in those instances where specific medical bills were denied, but then were paid, prior to the issuance of the Industrial Commission's decision regarding compensability of the same. The Court has never been asked to apply *Neel* where the claimant's potential exposure for payment of full invoiced amounts does not exist. Thus, even

were Millard to prevail on the substantive issues posed, Defendants would not have been remiss in making the arguments they have made. There is no basis for attorney's fees.

IV.

CONCLUSION

In *Neel*, the Industrial Commission expressed concern that where a claim was denied, the claimant had to go outside the work comp arena and contract directly with the medical providers for services, which potentially obligated him to pay full invoiced amount. No evidence was ever offered in support of the proposition upon which the decision was based. Keep in mind, in the vast majority of situations where a claim is denied, no expensive treatment requiring surgery and/or hospitalization is going to be made other than in an emergency situation where there is no potential payor out there other than the claimant. Hospitals and physicians do not usually perform back surgeries, etc., unless there is a known payor. Thus, the vast majority of situations where the claimant truly has some potential exposure for full invoiced amounts really means that there will not be any definitive medical care until after the matter has been deemed compensable, and of course, those medicals, having been incurred after the matter is deemed compensable, will come under the fee schedule.

The vast majority of situations where people get definitive medical care during a period of time that the claim is denied occur where there is some other payor, be it Medicaid, Medicare, or a health carrier. Both Medicaid and Medicare prohibit balance billing such that, a few co-pays aside, a claimant has no further risk or exposure and will never be subjected to payment of full invoiced amount. Most health carriers have similar prohibitions against balance billing other than

deductibles and co-pays, although not as predictable as Medicare. Mr. Millard had no exposures for full invoiced amounts as to the injections by Dr. Garg or the physical therapy, because both were paid by Medicare.

Defendants do not imply that a work comp carrier whose denial has been rejected by Industrial Commission order should somehow be able to simply reimburse a health carrier, Medicaid, or Medicare what they paid along with the claimant's deductibles and walk away. Defendants believe that the appropriate solution is, a claim, having been found compensable, payments made by a health carrier, Medicare, or Medicaid, should be unwound, new bills sent to the work comp carrier, and those bills processed under the fee schedule ordered by the Idaho legislature as required by Idaho Code § 72-803. Defendants further believe that in those isolated situations where a claimant truly has exposure for full invoiced amount or has been held responsible to pay full invoiced amount, as for instance by means of a district court judgment, then the employer/surety should pay that amount. Defendants' position would be that the controlling statute, Idaho Code § 72-432, which requires the employer/surety to pay for reasonable medical services, meaning reasonable both in the nature of the service and in the amount, immediately following an accident and injury and for a reasonable time thereafter, requires such a result. Defendants believe that in those instances where for instance a health provider has obtained a district court order ordering a claimant to pay the full invoiced amount, what becomes reasonable is what the injured worker is required to pay pursuant to the order. Defendants believe that in those situations where a claimant has not been ordered to pay the full invoiced amount, but is only subjected to the potential, that the amount that is reasonable to pay

under § 72-432 is what is fee scheduled, as stated in § 72-803. The Industrial Commission for many years has routinely dealt with medical bills incurred ostensibly outside workers' compensation to the extent they are incurred before there is a claim or to the extent they are incurred during a denial, and over its long history has had no problem ordering sureties to pay those at some reasonable rate up until *Sangster* and *Neel.* It just so happens that the reasonable rate in modern times happens to be per the fee schedule. Defendants believe that the argument about contractually incurred outside workers' compensation should be limited in its application.

The *Neel* Doctrine is the law by virtue of this Court's decision in the same case. As such, it is for the Court to determine how broadly or narrowly the doctrine should be implemented. Defendants suggest that where the surety, having denied a particular medical treatment or bill subsequently reconsiders its position and accepts the same prior to the entry of an Industrial Commission decision, it should be allowed to do so utilizing the fee schedule. To do so provides some incentive for the surety to reconsider its position, much for instance as occurred in this particular case as to the physical therapy bills that date from the fall of 2011. Defendants further suggest that the *Neel* Doctrine should not be applied in those instances where defendants have proven that a claimant has no exposures for full invoiced amount. This should be so for the obvious reason that if the claimant has no such exposure, then the policy underlying *Neel* is not served and there can be no excuse for what becomes an obvious windfall to the claimant and his counsel. To the extent that *Neel* is predicated on real or potential exposures for full invoiced amount, it should only be applied in those instances where such risks exist. Otherwise, it simply

becomes a penalty imposed by case law where the Idaho legislature has already spoken by means of Idaho Code § 72-804.

Mr. Millard's arguments apparently are based upon the notion that the Surety needs to be punished further. Mr. Millard's arguments are not based upon the notion that they have continuing exposures for full invoiced amount as to the medical contested, but, rather, that the Surety needs to be punished. Penalties for unreasonable denials and delays are limited to remedies provided in Idaho Code § 72-804. Neither the Industrial Commission nor the Court have ever suggested that the *Neel* Doctrine acts to work as a penalty, nor should the Court in the present instance.

DATED this 24th day of February, 2016.

BOWEN & BAILEY, LLP

R. Daniel Bowen – of the Firm
Attorneys for Defendants/Respondents

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 24th day of February, 2016, two true and correct copies of the foregoing document were served upon the following party(ies) in the method indicated:

JAMES D RUCHTI ESQ
RUCHTI & BECK LAW OFFICES
275 S 5TH AVE STE 140
POCATELLO ID 83201
FAX: (208) 232-5100

☒ U.S. MAIL
☐ HAND DELIVERY
☒ FACSIMILE

R. Daniel Bowen